Public Health Advocacy: Process and Product

Katherine Kaufer Christoffel, MD, MPH

A B S T R A C T

Objectives. In this article the author describes public health advocacy and proposes a conceptual framework for understanding how it works.

Methods. The proposed framework incorporates the image of an assembly line. The public health advocacy assembly line produces changes in societal resource allocation that are necessary for optimizing public health. The framework involves 3 main stages: information, strategy, and action. These stages are conceptually sequential but, in practice, simultaneous. The work at each stage is continually adjusted according to circumstances at the other stages.

Results. The framework has practical implications; for example, public health advocacy teams need members with complementary skills in distinct roles. Potential applications are illustrated via two public health advocacy efforts.

Conclusions. The framework may be useful in assessing staffing and funding needs for public health advocacy endeavors, explaining common problems in these endeavors and suggesting solutions, and guiding decisions concerning effort allocation. Application of the framework to a variety of public health advocacy endeavors will clarify its strengths and weaknesses. (*Am J Public Health.* 2000;90: 722–726)

Leading causes of mortality and morbidity affect not only individual health but also the public health. As a result, they deplete social as well as personal resources. Salient among these problems today are infections (e.g., HIV), chronic diseases (e.g., diabetes), and injuries (e.g., those due to motor vehicles).

Although the series of events leading to death and disability from such problems is manifest in individuals, these events are usually (perhaps always) fostered by psychosocial and physical phenomena that are key to disease occurrence or severity and that operate in populations or subpopulations. Contributing factors include prevalent toxic and addictive *substances and products* (e.g., cigarettes); *cultural patterns* (e.g., violence); and commercial promotion of personal *lifestyle* options that involve self-destructive habits (e.g., sedentary living).

Reducing the societal burden of public health problems requires interventions designed to alter the societal factors that foster these problems. Although such work is widespread, its processes and products have not been well described.

In this article, I describe the players and goals involved in advocacy efforts designed to improve the public's health, and I propose a conceptual framework for understanding how they are related. The framework is based on my observations over 2 decades, particularly while working to reduce child and adolescent injuries. (It is not based on previous scholarship or empirical research, except as noted.) It is intended to shorten the learning curve for newcomers to public health advocacy. Along with some of my colleagues, I have found the framework useful in recent working and teaching, and it may be similarly useful for others. It can be evaluated for utility and completeness by application to a variety of public health advocacy endeavors, past and future.

In the sections to follow, I provide (1) definitions of concepts used in the discussion, (2) a cataloguing of the processes and products of public health advocacy and of the types of individuals and organizations participating in it (at times using motor vehicle injury prevention as an example[1]), (3) a conceptual framework (or model) that organizes the catalog, and (4) suggestions on how the framework may be useful in planning and analysis of public health advocacy. I also provide examples of the framework's potential utility.

Definitions

Specific concepts are defined as follows. *Health problems* represent the range of physical and mental dysfunctions that reduce life duration, create sufficient acute or chronic disability to impede personal and community functions (including work and social interactions), and/or are treated by medical and allied care providers. Health problems become *public health problems* when they—actually or potentially—affect a substantial portion of a community (or a much higher proportion than in other communities), involve the use of substantial common resources, or alter the way the community functions or allocates its resources.

Advocacy is the application of information and resources (including finances, effort, and votes) to effect systemic changes that shape the way people in a community live. *Public health advocacy* is advocacy that is intended to reduce death or disability in groups

The author is with the Departments of Pediatrics and Preventive Medicine, Northwestern University, and the Violent Injury Prevention Center, Children's Memorial Hospital, Chicago, Ill.

Requests for reprints should be sent to Katherine Kaufer Christoffel, MD, MPH, Children's Memorial Hospital, 2300 Children's Plaza, Box 208, Chicago, IL 60614 (e-mail: kkauferchristoffel@nwu.edu).

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of people (overall or from a specific cause) and that is not confined to clinical settings. Such advocacy involves the use of information and resources to reduce the occurrence or severity of public health problems.

At least 2 broad levels of conduct are relevant to advocacy, including public health advocacy: (1) that of specific individuals and those with whom they live (labeled "individual" here) and (2) that of larger social networks to which individuals are tied by biology/genetics, relationships, geography, or civil jurisdiction (labeled "community").

TABLE 1—Examples of Changes That Are Intermediate Products of Public Health Advocacy

Individual/Family Level	Extended Family/Community Level
Reduced risk taking (e.g., substance abuse, unsafe sex, speeding)	Reduced risk tolerance (e.g., speed limits, gun commerce regulation)
Increased self-protection (e.g., seat-belt use, condom use, exercise)	Reduced environmental dangers (e.g., food contamination, soil and air toxins, product hazards)
Reduced personal isolation	Increased promotion of protections (e.g., safe havens, smoke detectors, immunizations)
Healthy diet	Facilitation of individual actions (e.g., assurance of health/dental care, public education, school-based health services)
Increased spacing between children, prenatal care	
Learning and application of stress reduction	
Regular health/dental care, including screening and treatment	

Components of Public Health Advocacy

Informal discussions of public health advocacy often assume that one or another specific action (e.g., legislation) constitutes its unique product or process. But a closer look shows that there are many products and processes involved.

Products

The final products of effective public health advocacy are reduced morbidity and mortality. Intermediate products include the bringing together of disparate forces to work for a common goal and changes in the conduct of individual and community life from behaviors that impede health to ones that promote it (or from behaviors that promote health problems to ones that do not). In efforts to reduce motor vehicle injuries, for example, intermediate goals have included a reduced frequency of drunk driving and increased safety belt use (at the individual level), along with improved vehicle construction standards and a reduced tolerance of drunk driving (at the community level).

Table 1 lists examples of the kinds of changes sought by public health advocacy for both individuals and communities. Effective reductions in public health problems usually require multiple changes at each level. Therefore, effective public health advocacy involves multiple intermediate products (e.g., passage of seat belt laws, increased traffic stops to screen for alcohol level), although strategies or tactics often dictate a focus on a single product (e.g., mandated air bags in the 1980s).

Processes

Public health advocacy activities include (at least) the following: (1) problem identification; (2) research and data gathering; (3) professional and clinical education, as well as education of those involved in the creation of public policy (including media coverage); (4) development and promotion of regulations and legislation; (5) endorsement of regulations and legislation via elections and government action; (6) enforcement of effective policies; and (7) policy process and outcome evaluations.

All of these activities occur in a context in which many groups and individuals are involved, often from distinct functional perspectives, including governmental (executive or legislative branch), geographic, religious, racial or ethnic, family, professional, and personal. The participants in public health advocacy work on its processes in distinct and overlapping ways, depending on their positions in society and the health care environment.

Conceptual Framework

Several authors have described the bases and processes of policy development and implementation in terms that are helpful for understanding public health policy.[2–4] There are conceptual frameworks for the process of public health practice,[5] types of prevention (primary, secondary, tertiary), and the foundations of public health progress (knowledge base, social strategy, political will).[6] Public health advocacy products, processes, and participants are part of a multidimensional effort that has frequently defied diagrams and clear conceptualization.

I suggest a conceptual framework for the process of public health advocacy that is consistent with others and is built on the image of an assembly line. In it, assembly of the products of public health advocacy occurs via 3 stages: *information, strategy,* and *action.* Each stage, in turn, contains multiple steps or components. The stages are conceptually sequential but, in practice, are generally simultaneous.

The *information stage* refers to the activities that are involved in identifying, describing, and quantifying the extent of a public health problem: its patterns of occurrence, risk and protective factors, causal sequences, program effectiveness for each level of prevention, barriers to effectiveness, and changes over time in all of these factors. The interim results of this stage generally appear as data reports, journal articles, and the like.

The *strategy stage* refers to the activities that are involved in using the available information to identify what needs to change to improve public health. This includes accurately conveying the information to professional and lay audiences, specifying discrete short-term objectives and time frames, mobilizing coalitions to work on the issue and toward the objectives, developing means to foster needed changes, and publicizing these elements. The interim results of this stage include policy statements, public education messages and campaigns, fact sheets, press conferences, news stories, strategy meetings, and networks of individuals and organizations.

The *action stage* refers to the activities involved in implementing specific strategies, including raising funds, specifying tactics, formulating detailed time lines, shifting the focus of staff in key organizations (e.g., local government) to the issue, convincing individuals to change their lives, convincing individual policymakers to get involved, crafting regulations and legislation, and pursuing the political activities needed to put these activities into effect (including anticipating and addressing challenges). The interim products of this stage include changes in attitudes, habits, resource allocation, the physical and social environments, social interaction, and societal rules that can affect the frequency or severity of public health problems.

The roles of the various participants in public health advocacy in these stages are outlined in Table 2.

How the Stages Fit Together

The work at each stage of the public health advocacy assembly line must be continually adjusted in the light of changing circumstances and progress—or setbacks—at the other stages. The interim results from each stage are used at the next stage to ensure that it is well conceived, likely to proceed reasonably smoothly, and likely to contribute to the products of public health advocacy.

For example, motor vehicle injury prevention relies on public health surveillance of fatalities and research on injuries and vehicles (at the information stage). That information is used to identify new or ongoing obstacles to continued declines in motor vehicle injury rates and also means to overcome these obstacles (at the strategy stage). Legislative lobbyists, staffers, and others then attempt (at the action stage) to alter policy by, for example, lowering illegal blood alcohol concentration levels and changing brake, air bag, and car seat performance standards.

TABLE 2—Public Health Advocacy Participant Roles, in Terms of the Proposed Framework

Participant	Information	Strategy	Action
Coalitions	Request data	Public education Policy focus identification Bring disparate players together Work with legislators Amplify group efforts Coordinate group efforts	Lobby Testify Get out the vote
Community groups	Tap resident knowledge Request data	Public education Join coalitions Work with legislators Mobilize residents	Lobby Testify
Individual health service providers	Case studies, series Research studies Define clinical issues	Clinical perspective Public education Build coalitions	Counsel Lobby Testify Vote
Health provider organizations	Identify needed data Some research	Policy statements Model bills Clinical guidelines Join/support coalitions Public education	Lobby Testify
Journal editors	Quality control via peer review	Special issues Choose reviewers	Publish papers and editorials Issue press releases
Journalists	Investigative work	Public education	Publish stories
Lawyers and other legal experts	Describe and interpret laws and their implications	Develop and teach options for application of and changes in laws	Bring suits and injunctions, draft rules and laws
Legislators	Request data Authorize data work Fund data work	Hold hearings Draft legislation Draft regulations	Pass laws Fund enforcement
Private sector (sometimes including manufacturers and retailers)	Fund data work Fund research	Funding priorities Fund coalitions Fund public education	Apply safety standards
Researchers and academicians	Conduct research and evaluation	Develop data-based and theoretical concepts to guide prevention planning; educational curricula for students	Publish papers Write editorials Testify Media interviews Determine course and qualifying exam questions Vote
Research funding agencies	Fund research Quality control via peer review	Funding priorities Consensus statements	Testify
Victims	Bear witness Participate in research	Victim perspective Public education Join coalitions	Lobby Testify Vote

Utility of the Framework

The proposed framework identifies sets of distinguishable activities and their logical sequence. The fact that the components are distinguishable means that they involve distinct knowledge and skills. That the stages are logically sequential reflects the fact that attention shifts conceptually—temporally and, over the short term, from one stage to another in the course of public health advocacy on any given topic (e.g., air bags). Attention has to return to the first stage as information changes, and then the sequence is repeated. The implications of these observations for the practice of public health advocacy are profound.

First, while one can imagine a particular public health advocate having equally complete knowledge and skills for all of the tasks at each stage of the assembly line, this is not common. Therefore, the members of a strong team of advocates will have overlapping knowledge and skills rather than being equivalently equipped.

Second, the model specifies the range of areas in which the team needs expertise. It can thus guide the planning, staffing, and process evaluation of a comprehensive public health advocacy effort.

Third, the existence of distinct and sequential essential stages, involving individuals with distinct knowledge and skills, implies that each stage and participant should be judged by their contribution to the entire process. Although the last (action) stage is most visible, its success depends on the preceding stages. Evaluation and credit should be apportioned accordingly (i.e., they must apply to what is done in the information and strategy stages as well as in the action stage).

Fourth, the model places boundaries on the productivity that can be expected from any one public health advocacy participant. If a particular public health advocate is responsible for the work on every stage of a public health campaign, his or her attention is likely to alternate, for various intervals, from one stage to the next. As a result, when attention returns to information, work on strategy and action abates. If attention cannot be spared from these stages at a particular time, incorporation of new knowledge may be delayed instead.

Fifth, the model suggests that there are boundaries on the productivity that can be expected of a public health advocacy team of very limited size. If only 2 or 3 advocates work together, the depth of knowledge and skills at each stage is likely to be uneven and shallow in spots; the range of activities at each stage will be limited, and the (geographic or policy) reach of the effort will be constrained. These observations are descriptive rather than judgmental: small-team efforts can be critically important to a multiphasic public health advocacy campaign. The abilities and limits inherent in each effort simply need to be clearly understood by those involved in the effort and by those funding and evaluating it.

Because of these features, the model presented may be useful for analysis of the following:

- The current staffing of a particular public health advocacy effort, to assess whether it can effectively carry out each stage on the assembly line and the steps at each stage.
- The staffing of an organization that is involved in several public health advocacy efforts and how it allocates attention and energy along the assembly line to each effort.
- The most productive role of an individual in a particular public health advocacy effort or group of efforts, given that person's knowledge, skills, talents, and preferences.
- Any gaps in knowledge, skills, attention, or staffing that need to be corrected to enhance the quality and pace of public health advocacy product creation by any group or coalition.
- Funding needs, to ensure that each stage of the public health advocacy assembly line is fully staffed (in one enterprise or across several enterprises).

The model may also be helpful in explaining common problems in public health advocacy as well as in suggesting solutions. Experience on public health campaigns can make it clear that it is common for involved individuals to work—and to be expected by themselves and others to work—at all stages of the public health advocacy process, often simultaneously. Yet, real world efforts rarely meet these expectations, and the proposed framework suggests why. Some public health advocates have skills, knowledge, and potential contributions that span 2 stages, at least to some extent; rare individuals span 3 stages, although usually not for an extended period.

The proposed framework thus suggests some changes in how we "do business" in public health advocacy. The leaders of a specific public health advocacy effort can attempt to identify participating individuals whose skills differ and develop complementary, interacting, and distinct roles for them. The model predicts that if an effort is staffed with people who are more or less interchangeable, it is probably not well staffed. Furthermore, if the effort has distinct capacity at some stages of the assembly line but not at others, it probably will not succeed.

Organizations that field several public health advocacy efforts at any given time may do well to invest in staff who have expertise at each stage of the assembly line (even in certain steps at each stage) and to assign that phase of the work on each effort to the staff best able to complete it. Of course, content expertise is also needed for each campaign, so the process experts must work closely with identified campaign leaders with a focus on content. But the various content leaders usually found in such organizations cannot be expected to be able to step in and work effectively at each stage of the assembly line without process experts to structure and carry out the work. Shared process resources may sometimes be needed across organizations of similar types.

Individuals who work in public health advocacy—on one specific effort or a variety of efforts—can deliberately identify their own knowledge, skills, talents, and interests and where on the assembly line they can make the greatest contribution. This exercise can guide time allocation, acceptance or rejection of specific assignments, the promises one makes (to oneself and others) about what will be done, choices in continuing self-education, and identification of the types of people who need to be on the same team to ensure that shared work can be effective.

Funding agencies may find it helpful to use the framework to evaluate public health advocacy programs they are considering funding: assessing where the programs fit on the public health advocacy assembly line (on one or several topics), what changes are needed in how the programs are organized (separately or in coordination) to increase the likelihood of effectiveness, and whether additional programs with complementary strengths should be developed or funded at the same time. Such an analysis would augment, not replace, ones that consider program constituencies (e.g., health providers, community agencies, survivors) and loci of action (specific communities or societal arenas).

The potential utility of the proposed framework can be illustrated through descriptions of the work of 2 organizations.

The American Academy of Pediatrics (AAP) is a professional organization including more than 50 000 pediatricians. It has a long history of dedicated, efficient, and effective public health advocacy and has developed staffing and systems to support this advocacy. Its information-stage functions are fulfilled by in-house researchers who collect data in some areas of inquiry (e.g., via annual member surveys on varied topics) and by members and other consultants who work in committees, task forces, and other such bodies.

These bodies work at the strategy stage to identify and synthesize relevant data into policy statements and other documents. The strategy stage work also includes extensive information dissemination to AAP members, allied organizations, and the public by dedicated units within the academy and networking by the national organization, chapters, and members with other medical societies, community groups, and other relevant organizations.

The action-stage work is led by the AAP staff devoted to government affairs, who track and lobby on federal and state legislation and regulation, and by members and chapter representatives, who lobby with and for the national and local organizations and advise individual families in clinical settings.

The Handgun Epidemic Lowering Plan (HELP) Network is an international coalition of more than 120 medical and allied organizations working to reduce handgun deaths and injuries. Although it has been involved in some original research (on health department practices related to data tracking), HELP mainly relies on members and other experts to generate and identify critical information (i.e., for work at the information stage).

HELP's activities are concentrated at the strategy stage, including information compilation and dissemination to members, the media, and the public; policy focus development; policy campaign design; and network building. HELP has designated staff to oversee strategy development (a part-time medical director and a steering committee), network development and fund-raising (a full-time executive director), communications (via various arrangements over time), and administrative work (a part-time assistant).

At the action stage, HELP does limited lobbying on legislation and regulation related to its policy foci; in general, however, it relies on the lobbying arms of member organizations (e.g., the American Academy of Pediatrics) and allied groups (e.g., Handgun Control, Inc, the Violence Policy Center, the Coalition Against Handgun Violence, and state-level groups), which concentrate more of their expertise and efforts at this stage. This combination of approaches has enabled HELP to play a visible and focused role in a

larger public health advocacy endeavor with few staff.

There has not been a widely used framework (or model) for describing and explaining public health advocacy. The framework proposed here fills this void and so may help those involved in public health advocacy to build such work in a way that will make it as effective as possible.

More detailed analyses of a variety of public health advocacy endeavors will clarify the strengths and weaknesses of the proposed conceptual framework. □

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References

1. Bonnie RJ, Fulco CE, Liverman CT, eds. *Reducing the Burden of Injury.* Washington, DC: National Academy of Sciences; 1999:115–137.
2. Stone DS. Causal stories and the formation of policy agendas. *Political Sci Q.* 1989;104: 281–300.
3. Stone DA. *Policy Paradox and Political Reason.* New York, NY: HarperCollins Publishers; 1988.
4. Nelson BJ. *Making an Issue of Child Abuse: Political Agenda Setting for Social Problems.* Chicago, Ill: University of Chicago Press; 1984.
5. Mercy JA, Rosenberg ML, Powell KE, et al. Public health policy for preventing violence. *Health Aff.* 1993;12(4):7–29.
6. Atwood K, Colditz GA, Kawachi I. From public health science to prevention policy: placing science in its social and political contexts. *Am J Public Health.* 1997;87:1603–1606.